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Issue Date: 13 October 2004

IN THE MATTER OF:

WILMA J. BLANKENSHIP,
Widow of JERREL D. BLANKENSHIP,
Claimant,

v. Case No.: 2003-BLA-6262

CLINCHFIELD COAL CO.,
Employer,

and

DIRECTOR, OFFICE OF WORKERS'
COMPENSATION PROGRAMS,
Party-in-Interest.

APPEARANCES:

Joseph E. Wolfe
Wolfe Williams & Rutherford
Norton, Virginia
For the Claimant

Timothy W. Gresham
Penn, Stuart & Eskridge
Abingdon, Virginia
For the Employer

BEFORE: Thomas M. Burke
Associate Chief Administrative Law Judge

DECISION AND ORDER AWARDING SURVIVOR'S BENEFITS

This case arises from a claim for benefits filed under the Black Lung Benefits Act, as amended, at 30 U.S.C. §901 *et seq.* ("Act"), and the implementing regulations thereunder at 20 C.F.R. Parts 718 and 725 (2001). By order dated December 8, 2003, I granted Claimant's motion, agreed to by employer, for a decision on the record. The record was held open for thirty days to allow for the filing of briefs. The Employer filed its closing argument. The Claimant did not file a closing argument and the record is now closed. The decision in this matter is based

upon all documentary evidence admitted into the record and the arguments of the parties. There being no objections, I hereby admit the following documentary evidence: *Director's Exhibits (Dx.)* 1-60, and *Employer's Exhibits (Ex.)* 1-10. Claimant has not submitted any exhibits.

Overview of the Black Lung Benefits Program

The Black Lung Benefits Act is designed to compensate those miners or survivors of miners who acquired pneumoconiosis, commonly referred to as "black lung disease," while working in the Nation's coal mines. Those miners who have worked in or around mines and have inhaled coal mine dust over a period of time, may contract black lung disease. This disease may eventually render the miner totally disabled or contribute to his death.

Procedural History

1. Jerrel Blankenship filed a miner's claim on February 21, 1991. *Dx-1*.

2. After being scheduled for a formal hearing before Administrative Law Judge Joel R. Williams, by Order dated January 28, 1993, Judge Williams granted Mr. Blankenship's request that the matter be decided on the documentary evidence, without a hearing. *Dx-1*.

3. On June 18, 1993, Judge Williams issued a Decision and Order denying benefits. *Dx-1*.

4. Mr. Blankenship did not appeal the denial.

5. Mr. Blankenship died on November 21, 2000. *Dx-13*

6. The claimant, Wilma J. Blankenship, filed her claim for survivor's benefits on September 10, 2001. *Dx -3*.

Issues Presented for Adjudication and Stipulations

The following issues are listed as contested by the Director, on the CM-1025 in this survivor's claim: (1) the length of employment in or around one or more coal mines (the District Director had established 22 years); (2) whether the miner died due to pneumoconiosis, and (3) whether the claimant is an eligible dependant survivor of the miner. *Dx-58*.

The Employer has stipulated to the following: (1) eighteen years of coal mine employment; (2) that the claim was timely filed; and (3) that the miner had coal workers' pneumoconiosis and that it arose from his coal mine employment, based upon the autopsy evidence. The Employer contests that the miner's pneumoconiosis caused, contributed to or hastened the miner's death.[1] Employer's Closing Argument at 2.

1 Employer challenges the validity of certain regulatory amendments applicable to this claim. This Office is without

The Standard for Entitlement

Because this claim was filed after April 1, 1980, it is governed by the regulations at 20 C.F.R. Part 718 (2001).[2] Under §718.205, where there is no miner's claim filed prior to January 1, 1982 resulting in entitlement to benefits, a survivor who files a claim after January 1, 1982, as in this case, is entitled to benefits only upon demonstrating that the miner died due to pneumoconiosis.[3] Specifically, Claimant bears the burden of establishing each of the following elements by a preponderance of the evidence: (1) the miner suffered from pneumoconiosis; (2) his pneumoconiosis arose out of coal mine employment; and (3) he died due to pneumoconiosis. *See Gee v. W.G. Moore & Sons*, 9 B.L.R. 1-4 (1986)(en banc); *Baumgartner v. Director, OWCP*, 9 B.L.R. 1-65 (1986)(en banc). Evidence which is in equipoise is insufficient to sustain Claimant's burden in this regard. *Director, OWCP v. Greenwich Collieries, et al.*, 114 S. Ct. 2251 (1994), *aff'g sub. nom. Greenwich Collieries v. Director, OWCP*, 990 F.2d 730 (3d Cir. 1993). Failure to establish any one of these elements precludes entitlement to benefits.

Existence of Pneumoconiosis and its Etiology

Under the amended regulations, "pneumoconiosis" is defined to include both clinical and legal pneumoconiosis:

> (a) For the purpose of the Act, "pneumoconiosis" means a "a chronic dust disease of the lung and its sequelae, including respiratory and pulmonary impairments, arising out of coal mine employment." This definition includes both medical, or "clinical", pneumoconiosis and statutory, or "legal", pneumoconiosis.
>
> > (1) Clinical Pneumoconiosis. "Clinical pneumoconiosis" consists of those diseases recognized by the medical community as pneumoconioses, i.e., the conditions characterized by permanent deposition of substantial amounts of particulate matter in the lungs and the fibrotic reaction of the lung tissue to that deposition cause by dust exposure in coal mine employment. The definition includes, but is not limited to, coal workers' pneumoconiosis, anthracosilicosis, anthracosis, anthrosilicosis, massive pulmonary

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authority to rule on the validity of the Secretary's regulations, however, it is noted that the amendments at issue were found valid by the D.C. Circuit Court of Appeals in *National Mining Ass'n. v. Dep't. of Labor*, 292 F.3d 849 (D.C. Cir. 2002). As a result, Employer's objections are noted for appeal purposes.

2 As the miner last engaged in coal mine employment in the Commonwealth of Virginia, appellate jurisdiction of this matter lies with the Fourth Circuit Court of Appeals. *Shupe v. Director, OWCP*, 12 B.L.R. 1-200, 1-202 (1989)(en banc).

3 Because the survivor's claim was not filed prior to June 30, 1982, the presumption contained at 20 C.F.R. §718.306 is inapplicable and will not be discussed further.

> fibrosis, silicosis or silicotuberculosis, arising out of coal mine employment.
>
> (2) Legal Pneumoconiosis. "Legal pneumoconiosis" includes any chronic lung disease or impairment and its sequelae arising out of coal mine employment. This definition includes, but is not limited to, any chronic restrictive or obstructive pulmonary disease arising out of coal mine employment.
>
> (b) For purposes of this section, a disease "arising out of coal mine employment" includes any chronic pulmonary disease or respiratory or pulmonary impairment significantly related to, or substantially aggravated by, dust exposure in coal mine employment.
>
> (c) For purposes of this definition, "pneumoconiosis" is recognized as a latent and progressive disease which may first become detectable only after the cessation of coal mine dust exposure.

20 C.F.R. §718.201 (2001). Moreover, the regulations at 20 C.F.R. §718.203(b) (2001) provide that, if a miner suffers from pneumoconiosis and has engaged in coal mine employment for ten years or more, as in this case, there is a rebuttable presumption that the pneumoconiosis arose out of such employment.

As noted above, the Employer has stipulated that the miner had pneumoconiosis and that the miner's pneumoconiosis arose out of coal mine employment, based upon the autopsy evidence. Employer's Closing Argument at 2.

Establishing Death Due to Pneumoconiosis

Benefits are provided under the Act for survivors of miners who died due to pneumoconiosis. 20 C.F.R. §718.205 (2001). In particular, the provisions at 20 C.F.R. §718.205 (2001) require competent medical evidence, which (1) establishes that the miner died due to pneumoconiosis; or (2) that pneumoconiosis was a substantially contributing cause or factor leading to the miner's death or the death was caused by complications of pneumoconiosis; or (3) that the presumption of 20 C.F.R. §718.304 (2001) is applicable[4]. The regulations further provide that "[p]neumoconiosis is a 'substantial contributing cause' of a miner's death if it hastens the miner's death." 20 C.F.R. § 718.205(c)(5) (2001).

Medical opinions are relevant to the issues of whether the miner had pneumoconiosis and whether pneumoconiosis caused the miner's death. A "documented" opinion is one that sets

4 Because there is no evidence of complicated pneumoconiosis in this record, the presumption at § 718.304 is inapplicable and will not be discussed further. Moreover, the lay evidence provisions at § 718.204(c)(5) are inapplicable to this survivor's claim because it was filed after January 1, 1982. *See also Gessner v. Director, OWCP*, 11 B.L.R. 1-1, 1-3 (1987).

forth the clinical findings, observations, facts and other data on which the physician based the diagnosis. *Fields v. Island Creek Coal Co.*, 10 B.L.R. 1-19 (1987). An opinion may be adequately documented if it is based on items such as a physical examination, symptoms, and the patient's history. *See Hoffman v. B&G Construction Co.*, 8 B.L.R. 1-65 (1985); *Hess v. Clinchfield Coal Co.*, 7 B.L.R. 1-295 (1984). A report which is better supported by the objective medical evidence of record may be accorded greater probative value. *Minnich v. Pagnotti Enterprises, Inc.*, 9 B.L.R. 1-89, 1-90 n.1 (1986); *Wetzel v. Director, OWCP*, 8 B.L.R. 1-139 (1985).

A reasoned opinion is one in which the administrative law judge finds the underlying documentation adequate to support the physician's conclusions. *Fields, supra*. Indeed, whether a medical report is sufficiently documented and reasoned is for the administrative law judge as the finder-of-fact to decide. *Clark v. Karst-Robbins Coal Co.*, 12 B.L.R. 1-149 (1989)(en banc). Moreover, statutory pneumoconiosis is established by well-reasoned medical reports which support a finding that the miner's pulmonary or respiratory condition is significantly related to or substantially aggravated by coal dust exposure. *Wilburn v. Director, OWCP*, 11 B.L.R. 1-135 (1988). An equivocal opinion, however, may be given little weight. *Justice v. Island Creek Coal Co.*, 11 B.L.R. 1-91 (1988); *Snorton v. Zeigler Coal Co.*, 9 B.L.R. 1-106 (1986).

The following medical reports were admitted as evidence:

1. Eight exhibits were admitted into evidence which consist of treatment reports, discharge summaries and pathology reports related to the miner's various hospitalizations between June 1, 2000 and September 17, 2000. The various diagnoses included pneumonia; chronic obstructive pulmonary disease, most likely due to cigarette smoking; hypertension; coronary artery disease; gastroesophageal reflux disease; right upper lobe mass; metastasis to the sternum and left lower chest wall; inoperable squamous cell carcinoma of the lung; stage IV non-small cell moderately differentiated squamous cell bronchogenic carcinoma with new onset of hemoptysis; discectomy; emphysematous chest; history of myocardial infarction; major affective disorder depression; lumbar diskopathy; carcinoma of lungs, metastatic to bones; back pain with numbness in legs; metastatic neoplasm right fifth rib; tumor mass RUL; metastatic bronchogenic carcinoma stage IV to right intertrochanteric calcar area with impending pathologic fracture; newly diagnosed stage III-A squamous cell right lung cancer with metastasis to lumbar spine causing compression of cauda equine; and symptomatic hypercalcemia of malignancy. *Dx- 17*; *Ex- 1-8*.

2. The death certificate, signed by Dr. Anuradha Puri on November 27, 2000, listed multiple organ failure as a consequence of metastatic lung carcinoma as the cause of death. *Dx-13*.

3. An autopsy examination dated December 28, 2000 was performed by Dr. Larry Joyce. Dx-14. Dr. Joyce's credentials are not in the record. Dr. Joyce's final diagnosis with regard to the respiratory system listed "A) Coal workers' pneumoconiosis, diffuse, severe – coal macules all lobes and silicotic nodules within left upper lobe, subcarinal and right hilar and peribronchial lymph nodes. B) Squamous cell carcinoma, moderately differentiated – right upper lobe, with multiple metastatic tumor nodules throughout right upper lobe, right middle lobe, right lower lobe, left upper lobe, left lower lobe. C) Pulmonary emphysema, moderate to severe, with areas of interstitial fibrosis and atelectasis. D) acute bronchopneumonia, extensive in left lower lobe,

right lower lobe and right upper lobe, with multiple foci of microabscess formation and tissue destruction. E) Pulmonary edema and congestion, combined lung weight 1900 gm. F) Fibrous pleural adhesions, few. G) Pleural effusion, right, 100 cc – clear/yellow. *Dx-14*. Dr. Joyce's final diagnosis with regard to the thoracic cavity listed "A) Multiple metastatic foci of moderately differentiated squamous cell carcinoma throughout left and right chest was with areas of bone destruction identified." *Dx-14*.

4. In a consultation report prepared at the request of the Employer dated May 15, 2002, Dr. Richard L. Naeye reviewed the death certificate, an autopsy report, medical records from Buchanan General Hospital, Clinch Valley Medical Center and Duke University Medical Center, and medical information from Drs. Joyce, Patel, Ramakrishan, Nicholas, Guanlao, Puri, Kabaria and Kowatli. *Dx-35*. Dr. Naeye is board-certified in anatomic and clinical pathology. *Dx-35*. Dr. Naeye determined that "the microscopic findings identify the presence of moderately severe simple coal workers' pneumoconiosis (CWP) in this man. These findings are not representative of his lungs as a whole. The cancer, its therapy and their resultant fibrosis and pneumonia caused such severe damage in his lungs that he would have died weeks earlier if the lung tissues available for my review were representative of his lungs as a whole. It is important to recognize that his CWP was not recognized on x-rays by multiple B-readers. In the few lung areas where cancer and its consequences were mild, centrilobular emphysema and chronic bronchitis were the only disorders that could have measurably affected lung function. As will be discussed later coal mine dust has only a minor role in their genesis. The two disorders that are totally the consequence of mine dust exposure affected too little lung tissue to have had any clinical significance. These disorders are that thin rims of focal emphysema which surrounded a few anthracotic micronodules and the fibrous tissue that was sometimes admixed with the black pigment. The focal emphysema consitituted no more than 2-3% of the total emphysema in the lung tissue available for review. Most of the smaller black deposits in the lungs have neither admixed fibrous tissue nor rims of focal emphysema. Exposure to coal mine dust rarely has a significant role in the genesis of the two clinically important chronic disorders in this man's lungs. They are centrilobular emphysema and chronic bronchitis. In epidemiologic studies both of these disorders shorten lifespans. Studies of randomly selected populations of coal miners have shown no effect of mine dust exposure on life expectancy when cigarette smoking is taken into consideration. Such expectancy would surely have been reduced if exposure to coal mine dust had a significant role in the genesis of these two disorders. Coal mine dust exposure as well as cigarette smoking can lead to chronic bronchitis, and less often to chronic bronchiolitis. However, studies . . . indicate that bronchitis has little or no effect on lung function unless the ex-miner happened to be a smoker. Airway obstruction caused by centrilobular emphysema and bronchitis that is severe enough to preclude a miner from working is very rare, if it indeed occurs at all in the absence of cigarette smoking or complicated CWP. To support all of the above there is strong evidence that simple CWP does not progress after a miner leaves exposure to coal mine dust. Taking all of the above into consideration Jerrel Blankenship had mild to moderately severe simple coal workers' pneumoconiosis in his lungs. It was too mild to be recognized on x-rays and too mild to have caused any disability or to have hastened his death." *Dx-35*.

5. In a consultation report prepared on behalf of the Claimant dated October 25, 2002, Dr. Joshua A. Perper reviewed the autopsy report and slides, the death certificate, hospital and medical records, and x-ray, pulmonary function tests, blood gas studies and other laboratory

tests. *Dx-43*. Dr. Perper is board-certified in anatomical and surgical pathology, as well as forensic pathology, and is a clinical professor of pathology, epidemiology and public health. *Dx-43*. Dr. Perper made the following microscopic diagnoses: 1) Squamous cell carcinoma of the lung, moderate to poorly differentiated with intrapulmonary metastases; 2) simple coal workers' pneumoconiosis, moderate to severe, with macules, micronodules, macronodules, interstitial firbro-anthracotic and silicotic patterns; 3) Centrilobular emphysema, moderate to severe; 4) Sclerosis of intra-pulmonary blood vessels consistent with pulmonary hypertension; and 5) Silicotic intra-pulmonary and extra-pulmonary peri-bronchial and hilar lymph nodes. Dr. Perper acknowledged that Mr. Blankenship was a significant smoker and stated that although "it is true that centrilobular emphysema is a known complication of heavy smoking . . . as abundantly substantiated in reliable scientific literature in last decades, centrilobular emphysema is also a direct result of exposure to mixed coal mine containing silica and coal workers' pneumoconiosis. . . . While it is legitimate to recognize the role of smoking in producing centrilobular emphysema, it is equally legitimate to recognize the significant role of exposure to coal mine dust and coal workers' pneumoconiosis, and there is no logical reason to exclude it. As a matter of fact the scientific literature has recognized such significant role of exposure to coal mine dust and cetrilobular emphysema, as being significant beyond any effect that may be attributed to smoking, and coal workers' pneumoconiosis and its emphysema complications have been shown to progress after cessation of exposure to coal dust (because of the entrapped and retained intrapulmonary fibrogenic crystalline silica)" *Dx-43*. Dr. Perper also recognized what he characterized as a "growing body of scientific medical literature substantiating a causal connection between exposure to mixed coal mine dust and coal workers' pneumoconiosis and the development of lung cancer", noting that "[t]he clear presence of significant numbers of carcinogenic silica crystals in Mr.Blankenship's lungs, make such association very likely, and do not reasonably justify the exclusion to silica exposure as a pulmonary risk in addition to smoking." Dr. Perper stated that coal workers' pneumoconiosis "was a substantial contributory cause of Mr. Blankenship's death both directly and indirectly through the associated cetrilobular emphysema, that caused hypoxemia that either triggered or aggravated a fatal cardiac arrhythmia, and the complicating bronchopneumonia and pulmonary cancer." Dr. Perper concluded that "1. Mr. Blankenship had evidence of moderate to severe simple coal workers' pneumoconiosis, with associated severe centrilobular emphysema and partially associated pulmonary cancer, a combined result of exposure to coal mine dust containing silica and smoking. 2. Mr. Blankenship, a coal miner with an occupational exposure of more than eighteen (18) years developed coal workers' pneumoconiosis as a result or occupational exposure to coal mine dust, 3. Coal workers' pneumoconiosis with associated centilobular emphysema was a substantial contributory cause of Mr. Blankenship's death and hastened his demise, both directly and indirectly through hypoxemia and complicating bronchopneumonia, and through the complicating carcinoma of lung." *Dx – 43*.

6. In a letter dated December 26, 2002, Dr. Richard Naeye reviewed his previous report dated May 15, 2002, all of the slides with lung and nodal tissues that he had previously reviewed, a consultation report from Dr. Joshua Perper, and reprints of multiple published scientific papers cited by Dr. Perper in his report. *Dx-48*. After noting that Dr. Perper did not differentiate in his report between free silica and silicates, he stated that "there is reason to question whether he was mainly identifying the many non-toxic silicate crystals in the lungs of this man rather than the few toxic crystals of free silica in his report. Differentiating between the two is of great

importance in identifying both the genesis of the fibrosis in Jerrel Blankenship's lungs and the carcinoma that killed him". *Dx*-48. Dr. Naeye further states that "[u]nder the circumstances there is every reason to attribute the lung cancer that killed Jerrel Blankenship to his cigarette smoking" and that "Dr. Perper has reversed the chain of events that led to death. First, there is no clinical evidence that this man had clinically significant centrilobular emphysema. If he did heavy cigarette smoking characteristically has a much larger role in its genesis than exposure to mine dust." *Dx-48*. Finally, Dr. Naeye states that "Dr. Perper is basing his key opinions on four coal miners who developed lung cancer without knowing how much free silica was in their lungs and without recognizing the large U.S. and world literature that no relationship exists between mining coal and lung cancer." *Dx-48*.

7. At the request of Employer, Dr. P. Raphael Caffrey prepared a consultation report dated November 5, 2003. *Ex-9*. Dr. Caffrey is board-certified in anatomical and clinical pathology. He reviewed the medical history and x-ray reports, death certificate, autopsy and consultation reports, and autopsy slides, and concluded that although the miner had simple coal workers' pneumoconiosis of a mild to moderate degree, and centrilobular emphysema of a moderate degree, "the fact Mr. Blankenship was a coal miner . . . did not cause him any significant pulmonary disability and definitely did not cause, contribute to or hasten his death." *Ex-9*. Dr. Caffrey attributed Mr. Blankenship's medical problems to his smoking and concluded that "Dr. Perper in his report and references have not objectively documented that the patient's diseases from which he suffered, namely CWP and carcinoma of the lung were due to silica. It is my objective opinion that simple CWP and the centrilobular emphysema were not debilitating the patient up until the time he developed carcinoma of the lung. The carcinoma of the lung in my opinion definitely was due to his years of smoking cigarettes and the miner's death was due to widespread carcinoma of the lung with superimposed bronchopneumonia and abscess formation. Given Mr. Blankenship's smoking history, it is my opinion that he would have died at the same time and in the same way, whether or not he ever worked as a coal miner." *Ex-9*. He further stated that "Mr. Blankenship's death occurred in an individual who was a heavy smoker and who suffered from emphysema, chronic bronchitis, coronary artery disease and carcinoma of the lung in my opinion were a result of years of cigarette smoking." *Ex-9*.

8. At the request of Employer, Dr. James R. Castle prepared a consultation report dated November 18, 2003. *Ex-10*. Dr. Castle's credentials are not in the record. He reviewed the x-ray, pulmonary function study, and blood gas reports, the medical reports, death certificate, autopsy and consultation reports and concluded that Mr. Blankenship had simple coal worker's pneumoconiosis, pulmonary emphysema and metastatic squamous cell carcinoma of the lung. *Ex-10*. He opined that "the carcinoma of the lung was neither caused by, contributed to, or hastened by the simple coal workers' pneumoconiosis that was present pathologically or by his coal mine dust exposure. I disagree with the opinion of Dr. Perper that his coal mine dust exposure contributed to his carcinoma of the lung and therefore his death. It is my opinion that Mr. Blankenship died as a result of severe complicating pneumonia related to his tobacco smoke induced carcinoma of the lung. It is my opinion with a reasonable degree of medical certainty that Mr. Blankenship would have died as and when he did regardless of whether or not he had coal workers' pneumoconiosis and regardless of his occupational history. It is my opinion that he would have died as and when he did even if he had never been inside a coal mine." *Ex-10*.

Discussion

The miner had pneumoconiosis at the time of his death. All the physicians who provided reports since his death diagnosed pneumoconiosis and the Employer stipulates to its existence. (Employer's Closing Argument at 2) At issue is whether his pneumoconiosis was a substantially contributing factor leading to his death. The Death Certificate set forth the cause of death as multiple organ failure due to metastatic lung carcinoma. Dr. Joyce's autopsy report revealed squamous cell carcinoma as well as moderate to severe pulmonary emphysema and coal workers' pneumoconiosis of moderate to severe degree with multiple coal macules identified within each lobe, as well as silicotic nodules. Dr. Joyce offered no opinion on the particulars of the cause of death or whether the miner's coal mine dust exposure had any affect on his death. Dr. Naeye found the cause of death to be lung cancer attributed to cigarette smoking. His review of the autopsy record characterized the severity of the miner's pneumoconiosis as moderately severe, although he considered it to be too mild to have caused a disability or hastened the miner's death. He reasoned that the coal workers' pneumoconiosis was too mild to be seen on x-ray and is not a disease that would progress after the miner retired from mining. Dr. Naeye also diagnosed centrilobular emphysema and chronic bronchitis but offered the opinion that although these disorders could have affected the miner's lung function, they would not have been caused by coal dust in light of studies showing that coal dust is not a causative factor for these disorders in the absence of cigarette smoking.

Dr. Perper's autopsy review and report disagrees with the opinion of Dr. Naeye on whether coal dust exposure was a causative factor in the miner's death. Dr. Perper found that coal workers' pneumoconiosis with associated centrilobular emphysema was a substantial contributory cause of the miner's death and hastened his demise, both directly and indirectly through hypoxemia and complicating bronchopneumonia, and through the complicating carcinoma of the lung. Dr. Perper also offers the opinion that the miner's centrilobular emphysema and lung cancer were caused by his coal dust exposure. Dr. Perper, while acknowledging that smoking produces centrilobular emphysema and lung cancer, cites medical literature recognizing that coal dust plays a significant role in the causation of centrilobular emphysema, and he spoke of what he referred to as a growing body of scientific medical literature substantiating a causal connection between exposure to mixed coal mine dust and coal workers pneumoconiosis and the development of lung cancer.

Dr. Caffrey's review of the medical records and autopsy slides prompted his opinion that the miner's coal dust exposure did not cause, contribute to or hasten his death. He reasoned that death was caused by widespread carcinoma of the lung with superimposed bronchopneumonia and abscess formation. He dismissed pneumoconiosis and centrilobular emphysema as having an effect on the miner's death because of the degree of their involvement which he characterized as not debilitating up until the time the miner developed carcinoma of the lungs.

Although Dr. Naeye and Dr. Caffrey possess excellent credentials, their reports are given less weight than that of Dr. Perper because Dr. Perper's report is better supported by the record in that it is more in line with the findings of Dr. Joyce, the autopsy prosector. Dr. Joyce observed severe and diffuse pneumoconiosis with coal macules in all lobes and silicotic nodules within left upper lobe and bronchial lymph nodes. Dr. Perper observed moderate to severe

pneumoconiosis, with macules, micronodules, macronodules, interstitial firbro-anthracotic and silicotic patterns. These findings contrast with the dismissal by Dr. Naeye and Dr. Caffrey of pneumoconiosis as a condition affecting the miner's death because the pneumoconiosis was too mild. Dr. Naeye reasoned that the miner's pneumoconiosis was not severe enough to be recognized radiographically during his life, and "there is strong evidence that simple CWP does not progress after a miner leaves exposure to coal mine dust". *Dx-35*.

Dr. Perper addressed the issue of whether the miner's pneumoconiosis was significant enough to affect the miner's lungs in light of the history of negative x-ray readings. He observed that the pneumoconiosis was proven at autopsy to be significantly interstitial so that corresponding radiological findings could have been easily missed. He also states that "discrepancies in chest X-ray readings in cases of coal workers' pneumoconiosis are rather the rule than the exception, and the determining factors for the presence of pneumoconiosis are the pathological pulmonary findings…It is intriguing why the larger pneumoconiotic nodules demonstrated clearly at the autopsy were radiologically missed, but this is nevertheless the factual situation." *Dx-43*. Also, the basic premise underlying 20 C.F.R §725.309 (2000) and (2001) is that pneumoconiosis is a progressive and irreversible disease. *Lane Hollow Coal Co. v. Lockhart*, 137 F.3d 799, 803 (4th Cir. 1992). It can arise and progress even in the absence of continued exposure to coal dust. *Peabody Coal Co. v. Odom*, 342 F.3d 486 (6th Cir. 2003); *Lovilia Coal Co. v. Harvey*, 109 F.3d 445 (8th Cir. 1997); *LaBelle Processing v. Swarrow*, 72 F.2d 308 (3rd Cir. 1996).

Dr. Caffery cited three evaluations during the miner's lifetime which he believes shows that the miner did not have a serious pulmonary condition prior to the onset of the lung cancer. However, the only objective testing referenced by Dr. Caffrey as support for his finding of no incapacity before the lung cancer was performed in 1991, some nine years prior to the miner's death. Moreover, Dr. Sargent, as far back as January 1993, testified during a deposition, that he diagnosed mild to moderate obstructive lung disease in a November 11, 1991 examination.[5] Dr. Caffrey also points to a report dated June 30, 2000 by Dr. Weinacker as indicating no pulmonary incapacity because of an examination showing no shortness of breath at rest. However, page two of the same report reads that a review of the miner's respiratory system showed shortness of breath, cough and some shortness of breath while walking.[6]

Dr. Naeye and Dr. Caffrey principally criticize Dr Perper's opinions that the miner's centrilobular emphysema and lung cancer were caused or contributed to by his coal dust exposure. Both take issue with the medical literature cited by Dr. Perper on the relationship. However one need not reach the question of the etiology of the miner's lung cancer or centrilobular emphysema to find that the miner's death was substantially contributed to or hastened by his coal dust exposure. What is necessary is a determination of the soundness of Dr. Perper's opinion that the pneumoconiosis in and of itself was substantial enough to contribute to or hasten the miner's death.

5Deposition of Dr. Jeffery Dale Sargent, January 26, 1993. p. 29.
6 Employer's Exhibit 4; p.2.

Dr Castle is a pulmonary specialist. His consultation report is given less credit on the cause of the death than that of Dr. Perper. Dr. Castle finds pneumoconiosis but asserts that it had no affect on the miner's death. His argument is based on two considerations. He first argues that the miner's carcinoma of the lungs could not have been caused by coal dust as, in his opinion, there is no medical support for the proposition that coal dust exposure can cause lung cancer. However, as previously stated, the etiology of the miner's cancer need not be considered to reach the question of whether the miner's pneumoconiosis contributed to his demise. His second rationale is that the miner's pneumoconiosis was not serious enough to affect his death. That reasoning is based on his review of the record showing pulmonary function tests and arterial blood gas tests evidencing no disability, pneumoconiosis and chest x-rays that do not reveal opacities. However the objective testing referenced by Dr. Castle were the pulmonary function and arterial blood gas tests administered in 1991, some nine years prior to the miner's death, and Dr. Perper explained the reason that the miner's pneumoconiosis was not picked up by x-ray.

In sum, the medical opinion of Dr. Perper is entitled to the greatest weight. He possesses excellent credentials in the field of pathology, and his opinion is well-reasoned, well-documented and best supported by the record.

Eligible Survivor

The claimant was married to the miner in excess of ten years from September 28, 1957 until February 9, 1987, and therefore qualifies as an eligible surviving divorced spouse pursuant to 20 CFR § 725.212 and §725.216. The divorce decree ordered the miner pay claimant Five Hundred Fifty ($550.00) dollars per month as spousal support and maintenance. *Dx-12*. In addition, claimant indicated in Answers to Interrogatories dated April 3, 2002, that claimant "was getting a substantial part of my income from him after our divorce" and that "the alimony was $550 a month -& I got ½ of his unemployment". *Dx-31*.

Onset of Benefits

Where the claimant is an eligible survivor of the miner and entitled to benefits under the Act, as in this case, benefits must be paid beginning with the month of the miner's death but, in no instance, before January 1, 1974. 20 C.F.R. § 725.503(c) (2001). The survivor in this claim is entitled to benefits from November of 2000, the month in which the miner died. Accordingly,

ORDER

IT IS ORDERED that the claim for benefits filed by Wilma J. Blankenship is granted and benefits are payable commencing as of November, 2000.

IT IS FURTHER ORDERED that, within 30 days of the date of issuance of this *Decision,* Claimant's counsel shall file, with this Office and with opposing counsel, a petition for a representatives' fees and costs in accordance with the regulatory requirements set forth at 20 C.F.R. § 725.366 (2001). Counsel for the Director and Employer shall file any objections with this Office and with Claimant's counsel within 20 days of the date of receipt of the petition for fees and costs. It is requested that the petition for services and costs clearly state (1) counsel's

hourly rate and supporting argument or documentation therefore, (2) a clear itemization of the complexity and type of services rendered, and (3) that the petition contains a request for payment for services rendered and costs incurred before this Office only as the undersigned does not have authority to adjudicate fee petitions for work performed before the district director or appellate tribunals. *Ilkewicz v. Director, OWCP*, 4 B.L.R. 1-400 (1982).

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Thomas M. Burke
Associate Chief Administrative Law Judge

NOTICE OF APPEAL RIGHTS: Pursuant to 20 C.F.R. § 725.481, any party dissatisfied with this Decision and Order may appeal it to the Benefits Review Board within 30 (thirty) days from the date of this Decision by filing a Notice of Appeal with the Benefits Review Board at P.O. Box 37601, Washington, D.C. 20013-7601. A copy of this Notice of Appeal must also be served on Donald S. Shire, Associate Solicitor for Black Lung Benefits, 200 Constitution Avenue, N.W., Room N-2117, Washington, D.C. 20210.